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Ethnicity and religious coping with mental distress

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Abstract

Background: There is a growing evidence base for how people use religious and spiritual coping, and how coping patterns differ between ethnic groups.

Aims: To describe what constitutes religious coping and compare patterns of religious coping across ethnic groups.

Methods: In-depth interviews were completed by 116 people recruited from six ethnic groups. Subjects described how they cope with mental distress; their accounts were recorded, transcribed and subjected to the ''Framework'' approach to qualitative data analysis.

Results: Formalized religion was not always necessary for individuals to make use of religious coping. Religious coping was most commonly practiced by Bangladeshi Muslims and African Caribbean Christians. Coping included prayer, listening to religious radio, using amulets, talking to God, having a relationship with God and having trust in God. Cultural or spiritual coping practices were indistinguishable from religious coping among Muslims. There was a greater degree of choice and personal responsibility for change among Christians who showed a less deferential and more conversational quality to their relationship with God. Religious and spiritual coping practices were frequently used, and led to a change in emotional states.

Conclusions: People use religious coping, and this has implications for promoting resilience and recovery.

Keywords: *Religious coping, spiritual coping, distress, ethnicity*

Introduction

Although religious beliefs and practices have been of interest to health professionals, historically, this has mainly been to explore religiosity as an abnormal phenomenon (Crossley, 1995; Johnson, 1994). Indeed, sociological and historical analyses suggested that religious activity was unhelpful and oppressive and misrepresented reality (Morris, 1987). A contrasting view is that religious beliefs offer meaning to human existence and provide a guide for living (Geertz, 1975). For example, religious conversions can lead to a loss of worry and are used to cope with misfortune (James, 1975).

More recent data suggest that religious behaviours and beliefs can have a protective influence that moderate the impact of adverse interpersonal life events and social adversity

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on physical and mental health (Krause, 1998; Matthews et al., 1998; Smith, McCullough, & Poll, 2003; Steffen, Hinderliter, Blumenthal, & Sherwood, 2001). For example, belief in a just, benevolent God, experience of God as a supportive partner in coping, and involvement in rituals and search for support through religion lead to better mental health (Pargament, Koenig, Tarakeshwar, & Hahn, 2001). However, recent studies suggest that religious beliefs and practices are not always positive; a poor quality ''relationship'' with God and religious conflicts are associated with poorer health outcomes and higher mortality (Kendler et al., 2003; Koenig, Bearon, Hover, & Travis, III, 1991; Pargament, Koenig, & Perez, 2000; Pargament et al., 2001).

Loewenthal and Cinnirella (1999) compared religious coping among ethnic groups; semi-structured interviews were conducted among 59 women of black Christian, white Christian, Hindu, Jewish and Muslim faiths. The efficacy of religious coping was explored for benefits for depression and schizophrenia. Muslim subjects reported a lack of faith to be a cause of depression. Religious prayer and beliefs, in contrast to medication and help seeking from doctors or psychiatrists, were considered helpful. In a related paper, Loewenthal, Cinnirella, Evdoka & Murphy (2001) interviewed 186 women and 97 men. The sample consisted mainly of Christians ($n = 130$), Jews ($n = 35$), Muslims (33), Hindus ($n = 18$) and other religions such as Sikhs, Buddhist and New Age ($n = 15$). In this sample, religious coping was considered ineffective, compared with social and cognitive coping. Faith, prayer, maintaining religious practice, and attending a place of worship were seen as the most effective. When group specific responses were examined, Muslims most often endorsed a religious solution. Christians more often thought prayer and praying for others were effective; Jewish people reported maintenance of religious practice, consulting a religious leader, and others praying for the sufferer more strongly than other groups. Thus religious practice can be central to coping with misfortune, and especially among some ethnic groups (Loewenthal, Cinnirella, Evdoka, & Murphy, 2001). Cinnirella and Loewenthal (1999) studied 52 women from diverse religious groups and ethnic groups, and concluded that stigma of mental illness led to a preference for private coping, and that this included religious coping. Furthermore, there was a fear of being misunderstood by health professionals from all non-white groups in this study and among Jewish subjects, perhaps arguing for ethnic and religiously specific services.

These studies do suggest that medication, medical assistance, and psychiatrists, or even psychotherapists are not favoured as a useful form of help. This warrants some consideration. Mental health professionals are now acknowledging a need to become more aware of religious issues in their work. For example, psychoanalysts and psychoanalytic psychotherapists report that the spirit may be the ''blind spot'' of psychoanalytic practice and training, concluding that patients would want to have spiritual issues explored and that these should not be prejudged as infantile or pathological (Simmonds, 2004). The distinction between religious coping and other coping styles in conventional psychotherapeutic and mental health care practices may not always be appropriate in a multi-cultural society. One proposed solution is to use religious idioms and metaphors directly in therapies and by doing so to include cultural and religious coping practices within formal psychotherapeutic models of practice (Azhar, Varma, & Dharap, 1994; Barrett, 1997; Neki, 1975; Westermeyer, 1973). By implication, professionals will then have to learn about the religious practices of service users. An explanation for the non-popularity of conventional mental health care is that professionals do not know about religious coping, and that there is a discrepancy in religiosity between patients and professionals; indeed, some researchers conclude that clinical care may be improved if mental health professionals were more religiously sensitive in consultations (Dein, 2004; Koenig et al., 1991; Neeleman & King, 1993).

In order to achieve religiously sensitive consultations, professionals need to know about and understand what constitutes religious coping, and then to identify which coping patterns and styles are helpful and why. Therefore, this paper explores the way people talk about religious coping and their faith, the way they construct their religious world, and how such constructions are experienced and embraced in order to manage misfortune and suffering. We use narrative methods that are recognised to carry greater validity because such research more closely reflects the views of service users, and these methods are especially useful for exploring new areas on which there is little information (Pope, Ziebland, & Mays, 2000; Ritchie, Spencer, & O'Connor, 2003).

Aims

We investigated patterns of religious coping among six ethnic groups recruited in the Ethnic Minority Psychiatric Illness Rates in the Community (EMPIRIC; O'Connor & Nazroo, 2002). This work formed part of the original analyses on coping, but this paper presents an extended analysis of religious coping styles.

We wished to explore (a) what constitutes religious coping, and (b) how this is perceived to moderate distress, and (c) whether these differ across ethnic groups.

Methods

The EMPIRIC study combined a quantitative epidemiological survey with a qualitative follow up study of mental distress among six ethnic groups: Bangladeshi, Caribbean, Indian, Irish, Pakistani and White British people (Sproston & Nazroo, 2002). For the quantitative survey, ethnic groups were identified by family of origin to form nationally representative samples of ethnic groups. The sample for the qualitative study was selected from people who participated in the quantitative survey and consented to be re-contacted about future research (O'Connor & Nazroo, 2002). Participants were purposively selected by the research team to ensure adequate representation of a range of demographic characteristics (Table I). The study was focused on people aged between 25 and 50 years old. The study included persons born in Great Britain, and migrants who moved to Great Britain for secondary school education before 11 years of age or had moved to this country at age 11 or later (which would mean that none of their primary school education would have taken place in the UK). In addition, participants were purposively selected to include those with and without a common mental disorder (measured using the Clinical Interview Schedule-Revised; (Lewis, Pelosi, Araya, & Dunn, 1992).

Letters of invitation were sent to all potential respondents, using the language in which the person had been interviewed in the survey. This gave those who did not wish to participate a further opportunity to withdraw. Fieldwork took place in August 2000 to March 2001 and located in areas where significant numbers of people from ethnic groups lived (Sproston & Nazroo, 2002). Interviews carried out in languages other than English were translated and transcribed by the interviewer to minimize the loss of context. The main foreign languages spoken were those originating from South Asia. Thirty-four of the interviews were conducted in languages other than English (Punjabi, Urdu, Hindi, Sylethi), all with people from one of the South Asian groups, but most commonly Bangladeshi people. Interviewees were given the option of being matched on language, gender, and ethnicity.

All interviews were in-depth, exploratory and interactive in form, based on a topic guide that was developed by the research team in conjunction with the commissioners. The interviews began by exploring events in the respondents' lives – such as housing, health,

Table I. Sample Profile to show representation of sub-groups.

Ethnic group	Bangl.	Black Caribb.	Indian	Irish	Pakist.	White British	Total
Male	9	9	7	8	8	8	49
Female	9	11	12	13	11	11	67
Age							
25–30	5	3	3	2	5	4	22
31–35	4	4	3	3	3	4	21
36–40	4	4	7	2	3	6	26
41–45	2	7	5	5	5	2	26
46–50	3	2	1	9	3	3	21
Migration							
Was born in UK or moved prior to age 11	6	14	10	16	9	19	74
Moved to UK at age 11 or later	12	6	9	5	10	0	42
CIS-R score							
>or=12	7	10	11	9	11	9	57
<12	11	10	8	12	8	10	59
Religion							
Christian	0	11	0	7	0	7	25
Muslim	18	0	3	0	19	0	40
Sikh	0	0	5	0	0	0	5
Hindu	0	0	6	0	0	0	6
Buddhist	0	0	0	1	0	0	1
Rastafarian	0	2	0	0	0	0	2
None	0	7	5	13	0	12	37
Social class							
Manual	8	9	7	5	9	6	44
Non-Manual	3	10	12	16	4	13	58
Not applicable*	7	1	0	0	6	0	14
Marital status							
Married	15	6	15	13	15	11	75
Divorced/Separated	2	4	2	5	2	1	16
Widowed	0	0	0	0	1	0	1
Single	1	10	2	3	1	7	24

*This includes those who had never had paid employment, and therefore could not be coded into an occupational class.

employment, family, relationship and household circumstances – and attempted to assess whether the respondent was currently experiencing any form of mental distress (O'Connor & Nazroo, 2002). Where respondents identified episodes of distress, the interview went on to explore the respondent's views about the origin of that distress, the meanings attached to the situation (by themselves and other people); the practical, emotional and physical ramifications; and the *ways in which respondents tried to cope with their experience*. Religious group membership, practice, and coping with distress were specific areas of the topic guide on which data are presented in this paper.

Although interviewers knew in advance whether respondents had common mental disorders as measured by the Clinical Interview Schedule (CIS-R score; Lewis et al., 1992), in the qualitative survey they were asked not to introduce this information into the interview at any point. Interviewers made no mention of distress or other associated terms

(such as stress, depression or anxiety) unless the participant introduced such topics into the discussion. Differences in the occurrence and nature of distress meant that the length of the interviews varied quite widely, ranging from as little as 30 minutes to over two hours. Interviews were carried out in respondents' own homes and they were paid £15 in appreciation of their time and help in taking part, as is usual with this type of research. All interviews were conducted alone to avoid distraction by family members and avoid response bias. Each was tape-recorded and transcribed verbatim for the purposes of analysis. All interviewers were trained and quality reviews of their interviews were ensured by random review of interview information and debriefs.

Analysis

Data were subjected to the *Framework* approach to analysis, a form of thematic analysis developed at the National Centre for Social Research in the UK (Pope et al., 2000; Ritchie et al., 2003). *Framework* treats every transcript in a systematic way within a common analytic framework, to ensure consistent and transparent analysis that ensures validity and reliability in interpreting findings. The stages of analysis involve familiarization with the transcribed data, and identification of emerging issues, to inform the development of a themed framework that is charted in a spreadsheet format. All information that was extracted from the transcripts was charted and independently inspected by two researchers. Disagreements were resolved by consensus.

The themed charts contain a variety of emergent topic headings that capture the meanings in the data. The context of the information is retained, and the page of the transcript from which it comes is noted so that it is possible to return to the transcript. Organizing the data in this way enables the views, circumstances and experiences of all respondents to be explored within a common analytical framework that is both grounded in and driven by their own accounts. The thematic charts allow for the full range of views and experiences to be compared and contrasted both across and within subjects, and patterns and themes can be identified and explored. The final stage involves classificatory and interpretative analysis of the charted data in order to identify and confirm patterns, explanations and consider questions and hypotheses posed by the findings.

The data present the themes that emerged from the analysis, but grouped by overarching themes by which these clustered: components of religious coping and religious explanations for symptoms of distress.

Results

Although this paper focuses on religious coping, the analyses we present must be placed in the context of other coping strategies that are more fully described in the EMPIRIC report (O'Connor & Nazroo, 2002; Sproston & Nazroo, 2002). These included stoicism, a positive outlook, survival thinking, hopefulness, drawing upon lived experience, normalizing, rationalization, avoidance, distraction/escapism, crying, responsibility for others and relaxation. These non-religious methods of coping were found not to vary by ethnic group in any discernible way.

Demographic characteristics

One hundred and sixteen people participated in the qualitative study (49 men and 67 women; see Table I). Overall, subjects belonged to the following religious groups:

Christian (25), Muslim (40), Sikh (5), Hindu (6), Buddhist (1), Rastafarian (1); 37 subjects reported no religious orientation. Seventy four people were born in the UK or arrived in the UK before the age of 11, while 42 subjects came to the UK after aged 11.

Recruitment was by ethnic group (see Table I), so data are reported by ethnic group wherever possible, but some ethnic groups did not report much religious coping. A proportion of people made no reference to religion (7 out of 17 Indians, 7 out of 19 Pakistani, 5 out of 18 Bangladeshis, 3/18 Black Caribbean people, 11/20 English people and 15/24 Irish people; Fisher's Exact $p = .03$). Thus the findings on formalized religious ways of coping relate mainly to Bangladeshi & Pakistani Muslims and Black Caribbean Christians (see Table I); few Indian subjects belonged to any one religious group so limiting the findings that might be attributed to a single religious group of Indian origin.

Components of religious coping

African Caribbean and Bangladeshi subjects most often reported that formalized religious practices were central to their coping when compared with other groups. The way each of these two groups used religious practices and rituals, and the quality of their relationship with God, differed. African Caribbean people, in marked contrast to the Pakistani and Bangladeshi groups, more often talked of using religious coping more flexibly in a manner that helped them make decisions.

African Caribbeans often used religion to help cope with distress irrespective of the degree religious convictions and practices. In their own words, they found *strength, knowledge, wisdom* and *guidance* but also an *inner glow, peace* and *understanding* through prayer and relating to God. African Caribbean subjects saw their relationship with God as being an individual relationship that was drawn on at particular times of difficulty, to overcome particular problems: a 43-year-old man from the Caribbean had lived in the UK since the age of 13. He talked to God saying: ''Lord this is hard I messed up it is not as if you are not providing for me''. A 44-year-old Caribbean woman, who had lived in the UK since the age of 15, was a single mother. She said: ''I don't believe in God but in Jesus Christ''. Despite saying she did not believe in God, she still said that God had helped her in a difficult situation, when her daughter was unwell. She prayed regularly, did not consider herself to be a practicing Christian, but *used her religion* to make sense of what was going on. This illustrates the use of religious beliefs and ritual by people who do not claim to have a religious identity when asked directly. She found an experience of *peace*. She also listened to Christian radio, and this made her feel *holy*. Her account suggested a changed experience of the self in response to relating to God and hearing religious radio. She did not feel compelled to be a part of the formal religious world and did not consider herself to have strong religious beliefs.

Bangladeshi subjects, who were Muslim, tended to show the greatest reliance on religious ways of coping. The Bangladeshi Muslims (more so than Pakistani Muslim) subjects tended to embrace distress and become more adherent to orthodox religious practice as a way of remedying distress. For example, some subjects distanced the self from bad (irreligious) feelings such as *greed*. Listening to religious words on tape was used as a way of *distancing* oneself from worries and *diverting one's mind*. There was a more accepting attitude and a desire to offer *service* to people, to offer *hospitality and respect*. Doing this led to *feeling good inside*. Prayer also did this and this led to having no worries. Prayer helped to *clear the mind* and see *what little problem there was*; this gave perspective to a problem. Reciting religious verses and also using prayer beads were other ways of inducing these states of *no worry*. The Bangladeshi respondents emphasised living *in the right way* and a responsibility to God that

included *not making a problem out* of their distress. If they have a difficulty then it was evidently acceptable to God; and so they felt they also had to accept it as natural life events and circumstances.

Differing degrees of religious adherence can therefore contribute to distress in families. A 46-year-old Pakistani had been in the UK since the age of 23; she talked of having a *Taveez* which was an amulet in which religious prayers were contained. She said it stopped her from getting frightened and she felt pious and more reassured that God would not wish hurt upon her. She expressed some difficulties in her marriage as her husband was not as religious as she, which led to some conflict.

The British and Irish people were distinct from the other ethnic groups in that they tended not to use religious coping. However, there were some paradoxical statements about not being religious yet using religious coping. For example, religion offered *moral guidance* and one respondent talked of being *brought up as a Catholic but not believing in Catholicism but more in Christianity*. He disagreed with some of the Catholic teachings and felt religion did not offer moral teaching on how to live and what to do. Some people had no religious beliefs but they did pray, for example, at times of bereavement. Religion also offered *spiritual relaxation* and opened people up to *feel calmer*. The Irish appeared not have a strong religious identity or to use religious beliefs particularly strongly in comparison with other groups. However, there were some accounts that they sought, rather than passively received, *guidance*, *wisdom* and *knowledge* through their religion. There was a greater sense of personal responsibility for determining their future, and they also found *calmness* in praying and religious involvement.

Religious explanations for symptoms of distress

Some respondents believed that their emotions were volatile because of irreligious actions, and that religious actions diminished unmanageable emotions. A 49-year-old Muslim Pakistani man came to the UK at the age of 15. He talked of having anger and going to his mother for advice. He *learnt to serve others* and felt that he *shouldn't be jealous or envious*. These feeling and sentiments reflected, for him, the origin of his discontent and anger. If able to do these things (relinquish jealousy and envy and serve others), *God will reward you*, he said. He also talked of stress as something that needed to shared and when one realized how hard the stress was for another person, *God will be pleased*. His purpose for sharing stress was not based on notions of catharsis but more on sharing the burden of another's suffering, and an awareness of its overwhelming nature.

A 47-year-old Bangladeshi woman, who had been in the UK since the age of 29, said: *if I miss prayers I don't feel good*. This could culminate in her developing "a temper"; she found that prayer kept this and other *illness away from the mind*. Anger, aggression and loss of control, common accompaniments to mental disorders, were seen as a response to not praying enough. She suggested that not talking about the problem kept the worry about it away from the mind, and so this was desirable. The *mind was then clean* and the *body would stay clean and strong*. This approach seemed to involve distraction in order to distance *worries from the mind* and contrasts with what is expected in introspective psychotherapeutic practice where displaying and taking charge of emotions is encouraged, and passivity discouraged.

Among British subjects, non-attendance at Church did not hinder people's beliefs and use of religion as a way of coping. One 32-year-old British woman talked of praying as an equivalent of a counselling relationship. She did not pray every night but prayed whether things were going well or badly. She felt God was looking after her and felt *a warm glow* with it. She felt that religion and God helped her to take on responsibility for herself.

Discussion

Religion or spirituality

A better understanding of religious coping may contribute to the development of clinical strategies to enhance religious practice in order to moderate mental distress. In a study of coping with common mental disorders, we recently reported that spiritual explanations for distress were reported most commonly by White British, Bangladeshi and African Caribbean subjects in East and South London (Bhui et al., 2006). Spirituality and religious practice are often not distinguished in clinical care. In the Cambridge dictionary, spirituality is defined as the quality of being concerned with deep, often religious, feelings and beliefs, rather than physical aspects of life. As such, spiritual aspects of coping are inherent in coping with all mental distress; for example, spiritual aspects of coping with depression include doubt and questioning everything, exhaustion, demoralization and feeling ground down (Culliford, 2002). Spirituality includes transcendence, personal relationships, a code to live by and specific religious beliefs as domains of spirituality (Culliford, 2002). Religious coping is more easily identified by reference to membership of specific religious groups and organizations, specific practices, religious identities, and knowledge.

Although we investigated coping styles for religious content, some aspects of coping inevitably appeared ''spiritual'' rather than being determined by strong religious beliefs; for example, listening to religious radio broadcasts, or selective prayer at a time of crisis in the absence of any formal membership of a religious group. This is likely to contribute to resilience; coping with mental distress and showing resilience through creativity are attributes that are grounded in spiritual as well as religious values and skills (Culliford, 2002).

Religious coping and therapeutic relationships

Religious and spiritual coping are human responses that are influenced by group cultures and practices. Our study confirmed the findings of Loewenthal et al. (Loewenthal & Cinnirella, 1999; Loewenthal et al., 2001) that Muslim and Black Caribbean Christians most often use religious coping strategies compared with other religious groups We did not investigate directly the quality of relationship with God, but the narrative accounts of Bangladeshi Muslims, and to a lesser extent Pakistani Muslims, showed a greater deference to their God, reflecting a more accepting and submissive relationship, but never a persecuted or troubled ambivalent relationship that might contribute to mental distress (Pargament et al., 2000). The Muslim subjects of Bangladeshi origin were more able to give them selves up to God's will, and to trust that there would be a favourable outcome. African Caribbean subjects tended to converse and still make independent decisions and take responsibility for them, reflecting a different relationship with their God. An awareness of these distinctions is important for clinicians who are making judgements about the cultural concordance of religious beliefs where these may be misattributed to be an expression of a mental illness rather than a coping style.

Can professionals use religious knowledge to enhance recovery? Previous work has shown that for Muslims, suffering and misfortune are seen as a trial, or test, that would not be inflicted if, in accord with God's will, it could not be endured (Schimmel, 1975). Therefore, religious coping may be a common cultural practice that for Muslims is indistinguishable from religious practice; talking with God and a relationship with God may constitute a form of cultural psychotherapy, or more likely a cultural way of coping with life and giving it meaning (Geertz, 1975; Morris, 1987). Health care and psychotherapeutic practices are

themselves products of culture, and will reflect healing traditions of their cultures including religious and spiritual coping where these are more prevalent. Hence, the absence of religious content or techniques in mental health care and psychotherapy practice in the UK may not reflect evidence that religious coping should be excluded, but simply that the evidence base is produced in a more secular society. Indeed, in some societies with more religious adherence psychotherapeutic models even deploy religious idioms directly (Azhar et al., 1994; Neki, 1975).

How does religious coping help?

Previous work shows that black and minority ethnic groups show greater reliance on religious coping when experiencing emotional distress (Beliappa, 1991; Loewenthal et al., 2001). Psychotherapy and mental health practitioners may find that supporting their coping strategies may improve resilience and promote recovery, especially if conventional psychiatric interventions are unattractive or culturally unacceptable.

For example, one study of 59 patients with schizophrenia, schizoaffective disorder and affective disorder, religious beliefs and practices provided supportive social networks (Sajid, 2002).

In an interview study of 282 people, religious activity was considered to be helpful by those who had never previously been depressed, by men more than women, and by Muslims compared to other groups (Loewenthal et al., 2001); Muslims were the most likely to use religious coping rather than seek out professional help or social support. These findings are concordant with our study in which Islam had a more all encompassing influence in people's lives than among the other religious beliefs. This may reflect the position of Muslim people in our study, that their faith was a total philosophy of life that determined everything they do (Esmail, 1996; Loewenthal et al., 2001), and not a more practical form of everyday religion where they exercized choice over which part of the religious system to follow. These findings are consistent with studies showing that Islam does not separate secular and religious, religion and politics: ''The Muslim's life is lived with a vivid sense of the presence of God, and the inescapable working of the divine destiny'' (Baasher, 2001; Loewenthal et al., 2001). The performance of religious tasks is perceived to overcome these human weaknesses and hence to improve mental health (Loewenthal et al., 2001; Segal, Williams, & Teasdale, 2002).

Indian and Pakistani subjects were practiced at not making their distress into a ''problem''. Unfortunately this is often misunderstood within a scientific paradigm as fatalism or an external locus of control. However refusing to make misfortune into a problem may have important benefits for people from all cultures and is currently a focus of interest within cognitive therapy (Loewenthal et al., 2001; Segal et al., 2002). Indeed, James (1975) classic thesis that religious practice, or conversion in his writings, is associated with a changed sense of self and mastery over worry was demonstrated by many subjects irrespective of ethnic group and religious group. This aspect of religious coping may be common to all groups, and may reflect a cognitive shift that is being harnessed by CBT type therapies to effect change in mental distress (Segal et al., 2002).

Limitations

Our study is limited in that we have tried to draw inferences across a number of distinct ethnic groups. Ethnicity is itself a contested classification; however, it is used in the national census and advocated in public health and social care research in order to provide

comparable results. We may not have included adequate numbers of smaller religious groups, for example, of particular Christian or Muslim denominations that might allow for a more fine grained analysis. Our findings were mainly of Christian and Muslim religious practice among our sample, and mainly Bangladeshi and Black Caribbean participants. However, religious practices and beliefs do vary by country and culture even for the same religious group, just as cultural beliefs and practices can vary within one ethnic group. Practitioners need to exercise some caution when applying group specific norms, religious or ethnic groups, and should really consider an individuals religious and cultural background as a factor which is explored for its meaning and relevance for that individual. Hindus and Sikhs were not present in sufficient numbers to draw firm conclusions on each of these groups. It may be that among very religious subjects; the findings reported so far may be common irrespective of religious group, and for example, our study we recruited a less religious Christian group rather than the findings reflecting something about Christianity itself.

Conclusions

First, participants frequently brought up religious issues and seemed to regard them as important when we have known for some time that mental health professionals tend to avoid the subject. Second, religious or spiritual coping is common when people face psychological difficulties, even among those who would not regard themselves as religious in the formal sense. Third, although more encompassing in Muslim people, elements of religious coping such as prayer, seeking guidance and receiving comfort were common to many people. Fourth, the two patterns most clearly recognisable were ''immersion'' in a religious faith with almost all aspects of life given over to religious guidance; this contrasted with a more utilitarian stance, where faith and prayer were used mainly to help people cope with emotional difficulties or stress. Finally, although these divisions sometimes went down ethnic lines (e.g., between white and African Caribbean Christians), more often they were characteristic of religious differences (Muslim compared to Christian people). These findings are important at policy, clinical and academic levels. For too long, religion and spirituality have been ignored as soft subjects that must remain outside serious scientific exploration.

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